

**LONG TERM CARE SEMI-ANNUAL REPORT
REPORTING PERIOD JULY 1, 2003 TO DEC. 31, 2003**

NURSING FACILITIES AND NURSING FACILITIES FOR MENTAL HEALTH

In accordance with KAR 28-39-163 (d), this report shall be filed with the Licensure, Certification & Evaluation Commission (LCE), Ks. Department on Aging by Jan. 9, 2004. Administrators shall indicate resident and employee data for the 6 month period - July 1, 2003 through December 31, 2003. Refer questions to Caryl Gill, LCE, (785) 296-4222.

- I. a) Was your facility in operation in the full six months of the reporting period (07/01/03 - 12/31/03)? ☐ YES ☐ NO
 b) If answer was "NO," how many days was your facility in operation? _____ days
- II. Resident Capacity: NF _____ NF/MH _____
- III. Resident Information (include only 24 hour residents in Nos. 1 through 14). Complete all blanks. If nothing to report, enter zero.

	NF	NFMH
1. Inpatient days of care during the six month reporting period	_____	_____
2. Admissions during the six month reporting period (include new admissions and re-admission)	_____	_____
3. Discharges by hospitalization	_____	_____
4. Discharges by death	_____	_____
5. Discharges by transfer to a LTC Unit in a hospital, another nursing facility or NF/MH	_____	_____
6. Discharges by transfer to a ALF, RHCF, Home Plus or Boarding Care	_____	_____
7. Discharges by transfer to community	_____	_____
8. Other discharges (excluding 3, 4, 5, 6, 7)	_____	_____
9. Total discharges during six month reporting period (sum of numbers 3 through 8)	_____	_____
10. Resident census on last day of reporting period	_____	_____
11. Respite care residents admitted during the six month reporting period (residents admitted on a temporary basis not to exceed 30 days)	_____	_____
12. Resident census. Indicate 24 hour resident census for your facility on each day during the week of November 16- 22, 2003. Sun _____ Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____		

Note: Do not include day of discharge or days resident was hospitalized.

13. Adult Day Care (ADC) residents are persons who spend part of the day at the facility and return to their own home part of the day.
 ADC Participant Census:
 Sun _____ Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____
14. ADC Hours Provided:
 Sun _____ Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____

IV. Staffing Information. Complete all blanks. If nothing to report, enter zero.

15. Number of Direct Care Staff. Include employees on payroll and those hired through contract who provide direct care. Indicate below how many full-time and part-time staff were in the position listed during the **week of November 16-22, 2003.**

Direct Care Staff	NF or NFMH # Full-Time	NF or NFMH # Part-Time
Registered Nurses		
Licensed Practical Nurses		
Medication Aides (CMA's, LMHT's)		
Nurse Aides (CNA's) (Exclude CMA's, LMHT's)		
Nurse Aide Trainees		
Activities Staff		
Social Service Staff		
Licensed Social Workers (Do not include consultants)		

16. Number of Hours Worked Each Day (24 hours) by Staff in Selected Positions in the Nursing Facility or Nursing Facility for Mental Health during the **week of November 16-22, 2003**. Indicate below hours actually worked by shift by all staff (full-time and part-time) for the positions listed below. Report number of hours worked in **whole numbers only**. If your facility uses two 12 hour shifts, report hours as though the facility uses three 8 hour shifts.

DAY SHIFT	Sun	Mon	Tue	Wed	Thur	Fri	Sat
1. Registered Nurses*							
2. Licensed Practical Nurses							
3. Medication Aides (CMA's, LMHT's)							
4. Nurse Aides (CNA's)							
5. Nurse Aide Trainees							
6. Activities Staff							
7. Social Service Staff (Exclude LSW)							
8. Licensed Social Worker							
EVENING SHIFT	Sun	Mon	Tue	Wed	Thur	Fri	Sat
1. Registered Nurses*							
2. Licensed Practical Nurses							
3. Medication Aides (CMA's, LMHT's)							
4. Nurse Aides (CNA's)							
5. Nurse Aide Trainees							
6. Activities Staff							
7. Social Service Staff (Exclude LSW)							
8. Licensed Social Worker							
NIGHT SHIFT	Sun	Mon	Tue	Wed	Thur	Fri	Sat
1. Registered Nurses*							
2. Licensed Practical Nurses							
3. Medication Aides (CMA's, LMHT's)							
4. Nurse Aides (CNA's)							
5. Nurse Aide Trainees							
6. Activities Staff							
7. Social Service Staff (Exclude LSW)							
8. Licensed Social Worker							

I verify this information is correct and staffing information can be verified by payroll records.

Signature of Administrator	License No.	Date (mm/dd/yyyy)	E mail address	Phone Number
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